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MAY 13 2005

No. 04-1367

In the Supreme Court of the United States

KENIA M. CINTRÓN PADILLA, ET VIR,
Petitioners,

v.

ELI LILLY INDUSTRIES, INC., ET AL.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the First Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

I. Should an appellate Court review the merits of a district court judgment or order if the time period to file an appeal has elapsed?

II. Does an ERISA plan administrator act arbitrarily or capriciously when it denies a claim for long-term disability benefits if a claimant fails to provide sufficient information to demonstrate a claimed disability and refuses to complete an independent medical evaluation required by the plan?

PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT

Respondents Lilly Del Caribe, Inc., Eli Lilly Industries, Inc., and Eli Lilly Industries, Inc., Health, Welfare and Disability Plan ("Respondents" or "Lilly") state as follows:

1. All interested parties to this proceeding are identified in the caption.

2. Lilly del Caribe, Inc. and Eli Lilly Industries, Inc. are wholly-owned subsidiaries of Eli Lilly and Company, their parent company. The Eli Lilly Industries, Inc. Health, Welfare and Disability Plan, is sponsored by Eli Lilly Industries.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITIES iv

STATEMENT OF THE CASE 1

CERTIORARI SHOULD NOT BE GRANTED 4

A. Standard for Granting Certiorari 4

B. The First Circuit Correctly Determined that Petitioners' Appeal of Several Orders Was Untimely 5

C. The First Circuit Correctly Determined that the District Court Did Not Abuse Its Discretion in Denying the Orders From Which A Timely Appeal Was Filed 7

D. On the Merits, the First Circuit Did Not Err When It Upheld the Denial of Petitioners' Claim for LTD - Benefits 9

CONCLUSION 19

APPENDIX

TABLE OF AUTHORITIES

Page

CASES:

Acevedo-Villalobos v. Hernández,
22 F.3d 384 (1st Cir. 1994) 6

Aybar v. Crispin-Reyes, 118 F.3d 10 (1st Cir. 1997) . . . 8

Black & Decker Disability Plan v. Nord,
538 U.S. 822 (2003) 17

Browder v. Director, Dep't. of Corrections,
434 U.S. 257 (1978) 5

Brown v. Retirement Committee of Briggs & Straton,
797 F.2d 521 (7th Cir. 1986) 16

DeWitt v. Penn-Del Directory Corp.,
106 F.3d 514 (3d Cir.1997) 16

Donaho v. FMC Corporation,
74 F.3d 894 (8th Cir. 1996) 16, 17

Doyle v. Paul Revere Life Ins. Co.,
144 F.3d 181 (1st Cir. 1998) 16

Elliott v. Sara Lee Corporation,
190 F.3d 601 (4th Cir. 1999) 17

Ellis v. Metropolitan Life Insurance Co.,
126 F.3d 228 (4th Cir. 1997) 17

Firestone Tire & Rubber Co. v. Bruch,
489 U.S. 101 (1989) 16

Glinka v. Maytag Corporation,
90 F.3d 72 (5th Cir. 1996) 8

Gochis v. Allstate Ins. Co.,
16 F.3d 12 (1st Cir. 1994) 9

Kearney v. Standard Ins. Co.,
175 F.3d 1084 (9th Cir. 1999) 16

Mariani-Giron v. Acevedo-Ruiz,
945 F.2d 1 (1st Cir. 1991) 8

Mirpuri v. Act Manufacturing, Inc.,
212 F.3d 624 (1st Cir. 1994) 9

Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto.
Ins. Co., 463 U.S. 29 (1983) 16

Pérez Pérez v. Popular Leasing Rental,
993 F.2d 281 (1st Cir. 1993) 5

Pinkay v. Andrews, 389 F.3d 853 (9th Cir. 2004) 9

Rodríguez-Antuna v. Chase Manhattan Bank Corp.,
871 F.2d 1 (1st Cir. 1989) 8

Smith v. Unum Life Ins. Co. of America,
305 F.3d 789 (8th Cir. 2002) 17

Snow v. Standard Ins. Co.,
87 F.3d 327 (9th Cir. 1996) 16

Terry v. Bayer Corp., 145 F.3d 28 (1st Cir. 1998) 16

United States v. 789 Cases of Latex Surgeon Gloves,
13 F.3d 12 (1st Cir. 1993) 6

United States v. Helmsley,
864 F.2d 266 (2d Cir. 1998) 8

STATUTES

29 U.S.C. §§ 1001 *et seq.* 1

RULES AND REGULATIONS:

Fed. R. App. P. 27 (c) 5, 7
Fed. R. App. P. 4 (a) (1) (A) 5
Fed. R. App. P. 4(a)(4)(A) 6
Rule 27(c) of the Local Rules of the First Circuit 5
Rule 59(e) of the Federal Rules of
Civil Procedure 3, 5, 6, 8
Sup. Ct. R. 10 4

OTHER AUTHORITIES:

6A James W. Moore et al., Moore's Federal Practice,
¶ 59.13[3] at 59-282 (2d ed. 1993) 7

STATEMENT OF THE CASE

On March 5, 1999, Petitioners filed a Complaint before the United States District Court for the District of Puerto Rico, pursuant to the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* Petitioner Kenia Cintrón ("Cintrón") alleged that she was entitled to Short-Term Disability ("STD") and Long-Term Disability ("LTD") benefits under Respondents' Extended Disability and Employee Welfare Plans (collectively, the "LTD Plan" or "Plan").[1]

On August 14, 2002, the parties agreed to resolve the litigation and entered into a confidential settlement agreement (the "Agreement").[2] Under the terms of the Agreement, the parties agreed that Petitioners would receive a payment as described in the Agreement, and that Cintrón would be able to submit a claim for LTD benefits to the Benefit Plan Review Committee (the "Committee"), the administrative committee for initial appeals, subject to the requirements of the LTD Plan. The parties also agreed that all remaining claims would be dismissed with prejudice, except that the claim for LTD

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[1] The Complaint and its subsequent Amended Complaint also alleged that Cintrón was entitled to certain pension and other benefits . Petitioners also alleged that the LTD Plan Administrator had failed to comply with requests for information and materials, and claimed that they were entitled to punitive damages in the amount of $10,000,000. The cause of action for damages was dismissed on December 21, 2000. See District Court Dkt. #24.

[2] Petitioners have filed the Agreement under seal before this Honorable Court. Respondents have separately filed the Exhibits to the Agreement (e.g., the LTD Plan), as an Appendix to this Opposition.

benefits under ERISA § 502(a)(1)(B) would be dismissed without prejudice. In the event that Cintron's claim for LTD benefits was denied, the District Court could review whether the Committee acted arbitrarily and capriciously. On August 14, 2002, the District Court issued a Judgment approving the terms of the Agreement. See District Court Dkt. #77.

Subsequently, Cintrón filed a claim for LTD benefits with the Committee. Pursuant to the terms of the LTD Plan, the Committee requested that she undergo an independent medical evaluation by a neurologist and a psychiatrist to assist the Committee in completing its evaluation of her claim. Despite repeated requests and her initial agreement to complete the evaluations, Cintrón failed to comply with the requests. Based on the information provided by Cintrón with her claim, the Committee determined that she failed to demonstrate that she was "disabled" under the terms of the LTD Plan. In addition, it found that she had failed to cooperate with the LTD evaluation process. Therefore, Cintrón's claim was denied.

Despite Cintron's ability under the Agreement to exhaust her administrative remedies by appealing the Committee's denial to the Employee Benefits Committee ("EBC"), the LTD plan administrator, Petitioners filed various motions seeking to set aside the Agreement between January and June 2003. Those motions were denied. Accordingly, Cintrón subsequently appealed the denial of LTD benefits to the EBC. Cintrón, however, again failed to complete an independent medical evaluation, as requested by the EBC and required by the LTD Plan. Based on its review of the information before it, the EBC upheld the denial of Cintrón's claim. The EBC found that it was unable to verify her claimed disability and that she failed to provide the necessary information to support

her entitlement to disability benefits pursuant to the terms of the LTD Plan.

On September 25, 2003, Petitioners requested that the District Court review the EBC's denial of the LTD claim. See District Court Dkt. #90. Respondents timely opposed Petitioner's request. See District Court Dkt. # 93. By order dated November 24, 2003, the District Court denied Petitioner's motion for review of the denial of LTD benefits. See District Court Dkt. #95.

Petitioners did not file an appeal from the November 24, 2003 Order but, instead, on December 8, 2003, they filed a Motion to Reconsider under Rule 59(e) of the Federal Rules of Civil Procedure. In response to the motion, the District Court issued an Order dated December 19, 2003, denying[3] Petitioners' motion to reconsider and stating that "[t]he reasons appear from the record and are summarized in dkt #93". See District Court Dkt. #98. Petitioners did not file an appeal from this Order within 30 days after its issuance.

Instead, on January 8, 2004, Petitioners filed yet another motion, this time requesting that the District Court expressly deny or grant their motion to reconsider. See District Court Dkt. #99. By order dated February 25, 2004, the District Court again denied Petitioners' motion for reconsideration, noting that it had already been denied. In addition, in a separate order dated February 25, 2004, the District Court found that several other motions were moot and determined that the case was "closed for all purposes". See District Court Dkt. #'s 101, 102.

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[3] The case docket reflects that the Court "terminated" the Motion for Reconsideration. See District Court Dkt. #98.

On March 22, 2004, Petitioners filed a Notice of Appeal before the United States Circuit Court of Appeals for the First Circuit ("First Circuit"). See District Court Dkt. #103. Petitioners sought to appeal the August 14, 2002 Judgment, and all other subsequent orders entered by the District Court.

On October 1, 2004, The First Circuit dismissed Petitioners' appeal in its entirety. The First Circuit concluded that Petitioners failed to timely appeal the Judgment and several other orders issued by the District Court. It also concluded that, as to the two February 25, 2004 orders from which Petitioners timely appealed, the District Court had not abused its discretion in denying Petitioners' requests. The captioned petition followed.

Petitioners now question the First Circuit's decision regarding the untimeliness of their appeal and the District Court's appropriate determination that the timely appealed orders were without merit, and the merits of Respondents' denial of the LTD benefits claim. Petitioners' unfounded claims have been reviewed multiple times and denied by the District Court and the First Circuit. Therefore, Certiorari should not be granted by this Honorable Court.

CERTIORARI SHOULD NOT BE GRANTED

A. Standard for Granting Certiorari

"Review on a writ of certiorari is not a mater of right, but of judicial discretion." Sup. Ct. R. 10. "A petition for a writ of certiorari will be granted only for compelling reasons." Id. Petitioners have not presented any compelling reasons for this Honorable Court to exercise its discretionary jurisdiction over their attempted appeal of the dismissal of their claims. Indeed, their claims were appropriately addressed by the

District Court and First Circuit below, and should not be disturbed by this Honorable Court.

B. The First Circuit Correctly Determined that Petitioners' Appeal of Several Orders Was Untimely

Rule 27(c) of the Local Rules of the First Circuit, in relevant part, provides that "[a]t any time, on such notice as the court may order, on motion of appellee or sua sponte, the court may dismiss the appeal or other request for relief or affirm and enforce the judgment or order below if the court lacks jurisdiction, or if it shall clearly appear that no substantial question is presented." See Loc. Fed. R. App. P. 27 (c).

An appeal from a judgment or order in a civil case "must be filed with the district clerk *within 30 days* after the judgment or order appealed from is entered". See Fed. R. App. P. 4 (a) (1) (A) (emphasis added). "Timely filing a notice of appeal is 'mandatory and jurisdictional'". Pérez Pérez v. Popular Leasing Rental, 993 F.2d 281, 283 (1st Cir. 1993), *citing* Browder v. Director, Dep't. of Corrections, 434 U.S. 257, 264 (1978).

Under the applicable rules, it is clear that the First Circuit correctly concluded that Petitioners were untimely in seeking to appeal the August 14, 2002 judgment and the July 1, 2004 order. Petitioners did not file an appeal within thirty days of either the August 14, 2002 judgment or the July 1, 2004 order, nor did they file any motions to alter or amend the judgment, or to reconsider the order, within 10 days of their respective issuances, pursuant to Rule 59(e) of the Federal Rules of Civil Procedure. Thus, the First Circuit did not have jurisdiction to entertain an appeal of such entries.

On the other hand, the order entered on November 24, 2003 denying Petitioners' request to reopen the case and review the denial of disability benefits to Cintrón was subject to a timely motion to reconsider, filed on December 8, 2003. See District Court Dkt. #97. Therefore, the time to file an appeal was tolled until the District Court denied said motion through its order dated December 19, 2003.[4] See District Court Dkt. #98. However, once that order was issued, the 30-day limit to appeal began.

Petitioners did not file an appeal of the December 19, 2003 Order but, instead, on January 8, 2004 they filed yet another motion requesting a denial or grant of their motion to reconsider. See District Court Dkt #100. This last motion is certainly not one of those contemplated by Fed. R. App. P. 4(a)(4)(A) as one which would toll the limit to appeal. Therefore, when Petitioners filed their Notice of Appeal before the First Circuit on March 22, 2003, the time limit to appeal from the November 24, 2003 and December 19, 2003 orders had expired. After all, "[a second] motion for reconsideration that is served more than ten days after the entry of judgment has no effect upon appeal time, which runs from the entry of the original order denying ... an alteration or amendment of the judgment". Acevedo-Villalobos, 22

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[4] A timely motion to alter or amend judgment under Rule 59(e) of the Federal Rules of Civil Procedure tolls the time for filing a notice of appeal, "and the time for filing the notice starts to run from the entry of the order denying said motion". Acevedo-Villalobos v. Hernández, 22 F.3d 384, 387 (1st Cir. 1994). See also United States v. 789 Cases of Latex Surgeon Gloves, 13 F.3d 12, 14 (1st Cir. 1993); Fed. R. App. P. 4(a)(4)(A). This motion is timely and, therefore, tolls the time to file a notice of appeal, *only* if served within 10 days after the entry of the judgment or order. See Fed.R.Civ.P. 59(e).

F.3d at 389, *citing* 6A James W. Moore et al., Moore's Federal Practice, ¶ 59.13[3] at 59-282 (2d ed. 1993). Consequently, the First Circuit also lacked jurisdiction and, thus, correctly concluded that Petitioners were also barred from seeking relief in connection with the November 24 and December 19, 2003 orders.

Inasmuch as Petitioners' appeal before the First Circuit was untimely, the judgment and orders for which the period to file an appeal had transpired became final, and could not be revisited by said Court. Accordingly, this Honorable Court should decline Petitioners' motion for review.

C. The First Circuit Correctly Determined that the District Court Did Not Abuse Its Discretion in Denying the Orders From Which A Timely Appeal Was Filed

The First Circuit has discretion to deny an appeal when it "clearly appear[s] that no substantial question is presented", which would require it to consider the appeal. Loc. Fed. R. App. P. 27(c). Given that the August 14, 2002 judgment and the November 23, 2003 and July 1, 2004 orders were not timely appealed, only the two February 25, 2004 orders remain. These orders simply clarified that the District Court (1) had already denied Petitioners' motion to reconsider, and (2) declared as moot a motion filed by Petitioners' attorneys to withdraw from legal representation and two motions for extension of time. See District Court Dkt. #'s 101, 102.

These orders presented no substantial questions for the First Circuit to review. Petitioners claim that the motions which resulted in the two February 25, 2004 orders should toll the period to file an appeal is without merit. Contrary to Petitioners' position, it has been repeatedly held that "[a]llowing subsequent motions to repeatedly toll the filing

period for a notice of appeal would encourage frivolous motions and undermine a fundamental canon of our legal system, to promote the finality of judgments". Aybar v. Crispin-Reyes, 118 F.3d 10, 14 (1st Cir. 1997), *citing* Glinka v. Maytag Corporation, 90 F.3d 72, 74 (5th Cir. 1996). See also United States v. Helmsley, 864 F.2d 266, 268 (2d Cir. 1998) (finality is "an essential tool in the efficient administration of justice").

Petitioners argue they did not file a "second motion for reconsideration", but that it was "a request for ruling for the First Reconsideration". See Petition for Writ of Certiorari at 23. Contrary to their argument, however, Petitioners have disregarded the fact that the District Court denied[5] their Rule 59(e) motion to reconsider on December 19, 2003 by stating that "[t]he reasons appear from the record and are summarized in dkt #93". See District Court Dkt. #98. Therefore, their motion for the District Court to either deny or grant their motion to reconsider was, in fact, a second motion for reconsideration.

Just as "an appeal from the denial of a Rule 59(e) motion is not an appeal from the underlying judgment"[6], an appeal from an order that simply reiterates a previous ruling on a motion to reconsider is not an appeal of the underlying denial of the motion to reconsider. Therefore, the First Circuit correctly concluded that the District Court had not abused its

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[5] The case docket reflects that the Court "terminated" the Motion for Reconsideration. See District Court Dkt. #98.

[6] Mariani-Giron v. Acevedo-Ruiz, 945 F.2d 1, 3 (1st Cir. 1991). See also Rodríguez-Antuna v. Chase Manhattan Bank Corp., 871 F.2d 1, 2-3 (1st Cir. 1989).

discretion in denying the second motion to reconsider through its February 25, 2004 order.

Similarly, in applying its own well-settled precedent, the First Circuit did not err when it reviewed the District Court's decision to deny the motion for an extension of time to file yet another motion for reconsideration and to appeal under an abuse of discretion standard. See Mirpuri v. Act Manufacturing, Inc., 212 F.3d 624, 627 (1st Cir. 1994) (motions to extend time for filing an appeal are reviewed for abuse of discretion); Gochis v. Allstate Ins. Co., 16 F.3d 12, 14 (1st Cir. 1994). The First Circuit determined that Petitioners had sufficient time to file a timely notice of appeal, yet failed to do so, and that there was no justification for their failure. Based on this fact, the First Circuit concluded that the District Court did not abuse its discretion. In applying that same standard here, there is no basis to find that the "lower court committed a clear error of judgment in the conclusion it reached after weighing the relevant factors." Pinkay v. Andrews, 389 F.3d 853, 857 (9th Cir. 2004). Therefore, the First Circuit's decision should be left undisturbed by this Honorable Court.

D. On the Merits, the First Circuit Did Not Err When It Upheld the Denial of Petitioners' Claim for LTD Benefits

Even if this Honorable Court were to conclude that Petitioners filed a timely appeal from the District Court's decision not to further review the denial of Cintrón's LTD benefits claim, a brief overview of the evidence demonstrates that the Committee did not act arbitrarily or capriciously when it denied the claim.

Pursuant to the August 14, 2002 Agreement, Cintrón agreed to submit her claim for LTD benefits to the Committee. Accordingly, on August 16, 2002, Cintrón submitted her claim. See, Request for Review, District Court Dkt. #90, at Exhibit 1.

Petitioners claim that the Agreement makes no mention of Cintrón's completion of an independent medical evaluation. Petitioners' argument fails to recognize that the Agreement expressly incorporated the LTD Plan itself, and provided that the claim would be subject to the requirements of the LTD Plan. See Agreement at ¶ 3. Under Section 6.02 (b) of the LTD Plan, the Committee may require an employee to submit to medical evaluations to determine the extent of a claimed illness or injury. The Committee may require the employee to undergo such examination as often as reasonably necessary to determine whether the employee meets the definition of "disabled" under Section 2.01 (a) (5) of the LTD Plan. See Appendix A to this Opposition.

Thus, and pursuant to Section 6.02(b) the Plan, by letter dated September 23, 2002, the Committee requested that Cintrón undergo an independent medical evaluation by a neurologist and a psychiatrist. To provide flexibility for Cintrón to choose the physicians most convenient for her, the Committee provided her the names of three (3) physicians in each discipline for her to choose the one she preferred. See, District Court Dkt. #90, at Exhibit 3. Instead of choosing her preferred physician, however, on September 26, 2002, Cintrón responded by questioning the Committee's authority to request that she participate in an independent medical evaluation. See, District Court Dkt. #90, at Exhibit 3.

As a result of Cintrón's non-compliance, which was beyond the Committee's control, on October 2, 2002, the

Committee notified her that a thirty (30) day extension would be necessary in order to render its decision. The extension was required to allow Cintrón to submit to the requested independent medical evaluation or decline the request and leave the matter to be decided based on the information previously submitted by her. The Committee expressly advised Cintrón that the independent evaluations were warranted because there appeared to be several areas of poor correlation between her reported symptoms and the diagnostic studies she provided. Cintrón was requested to provide the Committee her election of the preferred option within ten (10) days to give enough time for the arrangements to be made with the physicians and sufficient time to be allowed for them to render a report and for the Committee to consider them. See, Circuit Court Dkt. #90, at Exhibit 4.

On October 12, 2002, Cintrón provided additional reports to the Committee but failed to respond to its request for the independent medical evaluations. See, District Court Dkt. #90, at Exhibit 5. Subsequently, on October 21, 2002, Petitioners' then counsel requested: 1) that the Committee again inform Cintrón of the need for an independent medical evaluation; 2) that the Committee select the doctors for the evaluation, inasmuch as Cintrón was unwilling to do so; and 3) that she be informed of the dates of the examinations and she would appear to such evaluations. See, Respondents' Opposition to Request for Review and Petition for Oral Argument, District Court Dkt. #93, at Exhibit 1.

As requested, on October 28, 2002, Cintrón was informed of the two physicians selected to conduct the independent medical evaluations and the dates of those examinations. Pursuant to paragraph seven (7) of the Agreement, the Committee provided notice of an additional thirty (30) day extension for the Committee to render its decision to allow

Cintrón to attend the medical evaluations and for the doctors to render their reports. See, District Court Dkt. #93, at Exhibit 2.

Notwithstanding, on November 4, 2002, Cintrón failed to attend the scheduled medical appointment with Dr. Carlos Luciano, Neurologist. See, District Court Dkt. #93, at Exhibit 3. On November 8, 2002, Cintrón also refused to undergo the independent medical evaluations. See, District Court Dkt. #93, at Exhibit 4. Instead, on November 13, 2002, Cintrón submitted to the Committee a medical certificate from her treating psychiatrist, Dr. Héctor Torres. See District Court Dkt. #90, at Exhibit 6.

The Committee met on November 13, 2002 to review Cintrón's claim for benefits. The Committee determined that she failed to provide the necessary information to support her entitlement to disability benefits pursuant to the terms of the LTD Plan. Specifically, the Committee concluded that Petitioner

> complained of severe upper arm pain, neck pain and back pain for several years. The severity of [her] symptoms, however, are poorly correlated with the diagnostic studies performed between 1998-2002. X-rays, CT scans, MRI scans, bone scans and Doppler flow studies suggest mild degenerative disc disease without significant flow obstruction or nerve root compression. Such findings are not inconsistent with mild symptoms and/or the aging process. In addition, an emotional disease component is suggested by some evaluators, but the extent of the disease is unclear as well as what effective interventions have been offered and [her] compliance with such recommendations... [I]t was the lack of expected correlation between

> objective diagnostic studies and [her] claimed disability that prompted the request that [she] undergo an independent evaluation of both [her] physical and psychological health.

Thus, as a result of the lack of evidence supporting a disability as defined in the LTD Plan, as well as the fact that Cintrón refused to participate in an independent medical evaluation, the Committee decided to deny the claim. Cintrón was informed of the Committee's decision on December 2, 2002, including the specific reasons for the denial of her extended disability benefits and notice of her right to appeal said decision within 180 days of her receipt of the denial letter. See, District Court Dkt. #90, at Exhibit 8.

On May 29, 2003, Cintrón filed her appeal before the Employee Benefits Committee. See District Court Dkt. #90, at Exhibit 12. On June 5, 2003, the EBC acknowledged receipt of Cintrón's appeal and informed her that it would review her claim at its next scheduled meeting on June 23, 2003. Plaintiff was further informed that she should submit any additional information to the EBC before June 16, 2003, so that it could be considered. See District Court Dkt. #90, at Exhibit 11. No new information was provided.

On July 3, 2003, the EBC informed Cintrón that it had met on June 23, 2003 and that after a review of the information provided by her as part of her appeal, it was unable to verify her claimed disability. To further evaluate the appeal, the EBC requested that Cintrón receive an independent medical evaluation by both a neurologist and a psychiatrist. Once again, Cintrón was provided with a list of three (3) physicians in each discipline for her to choose or to have the physician selected for her. Cintrón was advised that should she refuse to submit herself to the independent medical

evaluations, the EBC would be required to review her appeal without such information and might deny her request based on her failure to comply with the terms of the Plan or because it lacked necessary information to confirm her claimed disability. The EBC further requested her to consider said communication as notice of the EBC's need for a forty-five (45) day extension to render its decision consistent with Section 6.05(b) of the Plan. See District Court Dkt. #90, Exhibit 13. On July 16, 2003, Cintrón did not agree to attend the independent medical evaluations. See, District Court Dkt. #90, Exhibit 14.

On August 22, 2003, the EBC contacted Cintrón by phone to determine whether she had undergone any of the independent medical evaluations or planned to do so. At that time, she indicated that she had not participated in the same. On August 25, 2003, the EBC advised Cintrón of the possibility that the EBC extend the ninety (90) day review period provided in Section 6.05(b) of the Plan for an additional thirty (30) days, up to and including September 26, 2003, for the Committee to decide her appeal if she wanted to participate in the independent medical evaluations. The EBC further informed plaintiff that

> [a]s described in the Committee's July 3, 2003 correspondence to you, the Committee requested (as did the Benefit Plan Review Committee before it) that you see a neurologist and a psychiatrist so that the Committee could further evaluate your claim to disability benefits. In response, you claimed that the Committee was modifying the Plan's requirements and questioned the Committee's authority to request an independent medical evaluation. Moreover, you indicated in your July 16 correspondence that you would not comply with the Committee's request

> without imposing additional conditions (e.g., requiring a medical questionnaire for your physicians). Last Friday, you confirmed that you had not seen any of the physicians outlined in the Committee's July 3 correspondence. . . . While you previously indicated a willingness to the Benefit Plan Review Committee to see physicians if it chose them and later failed to attend scheduled appointments with the selected physicians, the Committee is willing to agree to your request. . .

Therefore, the EBC once again allowed Cintrón to attend the independent medical evaluations so that it could consider such information to evaluate her claim. The EBC requested that Cintrón confirm whether she wanted additional time to attend the evaluations. See, District Court Dkt. #90, at Exhibit 16. On that same date, Cintrón responded to the EBC by again questioning its authority to request that she participate independent medical evaluations at all. See, District Court Dkt. #90, at Exhibit 15. Subsequently, on August 25, 2003, Cintrón refused to extend the review period so that she could attend any medical evaluations. See, District Court Dkt. #90, at Exhibit 17, page 2.

On August 27, 2003, the EBC denied Cintrón's appeal of the denial of LTD benefits. The EBC reiterated that, based on the information provided by her, she failed to provide necessary information to support her entitlement to disability benefits as required by the Plan. Specifically, the EBC determined that there were several areas of poor correlation between Cintrón's reported symptoms and the diagnostic studies provided by her. Moreover, the EBC also considered as a factor Cintrón's refusal to comply with the Committee's request that she participate in independent medical evaluations. See, District Court Dkt. #90, at Exhibit 18.

Both pursuant to the terms of the Agreement and the LTD Plan, inasmuch as discretionary authority is granted to the EBC to interpret the terms of the Plan, as well as to make decisions under the LTD Plan, the applicable standard in reviewing the denial of benefits is the arbitrary and capricious standard. See Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989). It is, of course, the hallmark of such review that ". . . a court is not to substitute its judgment for that of the [decision-maker]." Terry v. Bayer Corp., 145 F.3d 28, 40 (1st Cir. 1998) (citing Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983)). Rather, in the ERISA context, it has been held that under the arbitrary and capricious standard, " . . . a fiduciary's interpretation of a plan will not be disturbed if reasonable." Terry, 145 F.3d at 40 (citing DeWitt v. Penn-Del Directory Corp., 106 F.3d 514, 520 (3d Cir.1997)). Simply put, the administrator's determination will be upheld if it was within its authority, reasoned, and supported by substantial evidence in the record. See Doyle v. Paul Revere Life Ins. Co., 144 F.3d 181, 183-184 (1st Cir. 1998); Donaho v. FMC Corporation, 74 F.3d 894 (8th Cir. 1996).

Accordingly, "[w]hen such a power [to interpret the terms of the plan and to determine eligibility for benefits] has been conferred, the judicial role is limited to determining whether the. . . [Committee's] interpretation was made rationally and in good faith- *not whether it was right*." Brown v. Retirement Committee of Briggs & Straton, 797 F.2d 521, 529 (7th Cir. 1986). (Emphasis ours).[7] As a corollary, "substantial

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[7] See also Snow v. Standard Ins. Co., 87 F.3d 327, 332 (9th Cir. 1996), *overturned on other grounds by* Kearney v. Standard Ins. Co., 175 F.3d 1084, 1089-1090 (9th Cir. 1999) (*en banc*) (the abuse of discretion standard ". . . does not permit overturning a decision where there is relevant evidence [that] reasonable minds

evidence" to support an ERISA plan administrator's decision means evidence which is reasonably sufficient to support a conclusion, *even in the presence of contradictory evidence*. See Donaho v. FMC Corp., 74 F.3d 894, 899-900 (8th Cir. 1996), *overturned on other grounds by* Black & Decker Disability Plan v. Nord, 538 U.S. 822 (2003); Smith v. Unum Life Ins. Co. of America, 305 F.3d 789, 794 (8th Cir. 2002); Elliott v. Sara Lee Corporation, 190 F.3d 601, 606 (4th Cir. 1999); Ellis v. Metropolitan Life Insurance Co., 126 F.3d 228, 234 (4th Cir. 1997); Miller v. United Welfare Fund, 72 F.3d 1066, 1072 (2d Cir. 1995). Thus, absent bad faith or conflict of interest, a court may only overturn a plan administrator's decision if it is ". . without reason, unsupported by substantial evidence or erroneous as a matter of law." Donaho, 74 F.3d at 900. Such is not the situation in this case.

Pursuant to the terms of the LTD Plan, the term "disability" is defined as "the inability of an Employee to engage, for remuneration or profit, in any occupation commensurate with the Employee's education, training, and experience, provided that the inability results from an illness or accidental bodily injury that requires the Employee to be under the regular care of a Licensed Physician." See Section 2.01(a)(5) of Appendix A to this Opposition. Upon a review of the evidence submitted by Cintrón in support of her claim for LTD benefits, both the Committee and the EBC concluded that it was not sufficient to demonstrate a "disability" as defined in the LTD Plan. Specifically, it was concluded that, although Cintrón complained of severe upper arm pain, neck pain and back pain for several years, the severity of her

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might accept as adequate to support a conclusion even if it is possible to draw two inconsistent conclusions from the evidence.").

symptoms were poorly correlated with the diagnostic studies performed between 1998 and 2002. Both the Committee and the EBC reviewed the information provided by Petitioners, and concluded that it suggested mild degenerative disc disease without significant flow obstruction or nerve root compression, not inconsistent with mild symptoms or the aging process. In addition, the Committee and the EBC found that, although an emotional disease component was suggested by some evaluators, the extent of the disease was unclear as well as what effective interventions have been offered, or Cintron's compliance with such recommendations.[8]

Pursuant to the express terms of the LTD Plan, Respondents requested that Cintrón submit to an independent medical evaluation to assist it in evaluating her claim for benefits. She refused to do so on multiple occasions. Her refusal to do so alone constituted grounds for the denial of benefits. Nevertheless, the Committee and the EBC reviewed the information before it and determined that they lacked necessary information to confirm her claimed disability. Accordingly, her claim was denied. In light of the above, and given the discretionary authority granted to the EBC to interpret the terms of the LTD Plan and to make decisions in connection with eligibility for benefits, it is clear that Respondents did not act arbitrarily or capriciously in denying Petitioners' request for LTD benefits.

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[8] Even a brief review of the denial letters issued by the Committee and the EBC addresses Petitioners' unfounded claims that Cintron was not given the specific reasons for the denial of her LTD benefits claim. See Petitioner's Appendix at 351-355, 437-440.

CONCLUSION

Petitioners' claims are without merit. As determined by the District Court and the First Circuit Court of Appeals, Respondents did not act arbitrarily or capriciously in denying Petitioners' request for LTD benefits. Accordingly, Petitioners' Petition for Writ of Certiorari should be denied.

This 13th day of May, 2005.

Respectfully submitted,

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ELI LILLY AND COMPANY

EMPLOYEE WELFARE PLAN

Effective January 1, 1986
As Amended Effective January 1, 2002

Table of Contents

SECTION 1. ESTABLISHMENT 1a

1.01. The Establishment of the Welfare Plan 4a
1.02. Component Plans2 . . . . . 4a

SECTION 2. DEFINITIONS 5a

2.01. Definitions 5a

SECTION 3. BENEFITS 7a

3.01. Coverage and Benefits 7a
3.02. Payment of Benefits 7a
3.03. Tax Withholding 7a
3.04. Other Adjustments 7a
3.05. Payment to Participant or Beneficiary 8a

SECTION 4. ADMINISTRATION 9a

4.02. Named Fiduciary 9a
4.03. Powers and Duties of the Employee Benefits Committee 9a
4.04. Delegations of Authority By the Employee Benefits Committee 10a
4.05. Employment of Assistants 11a

SECTION 5. FUNDING [omitted from this appendix]

5.01. Welfare Plan is a Single Plan
5.02. Contributions to the Trust
5.03. Insurance Contracts
5.04. Employee Contributions

SECTION 6. AMENDMENT AND TERMINATION 12a

6.01. Amendment or Termination by the Company 12a
6.02. Insured Component Plans --Termination of the Contract by an Employer 12a
6.03. Amendment of Schedule A. 13a

SECTION 7. MISCELLANEOUS 15a

7.01. Governing Law 15a
7.02. Agent for Service for Process 15a
7.03. No Vested Rights 15a
7.04. Non-Alienation 16a
7.05. Spendthrift Provisions 16a
7.06. Non-Guarantee 16a
7.07. Indemnification of Certain Fiduciaries 16a
7.08. Employment Rights. 19a

SCHEDULE A [omitted from this appendix]

SECTION 1. ESTABLISHMENT

1.01. The Establishment of the Welfare Plan.

Eli Lilly and Company has established, effective January 1, 1986, a plan as hereinafter set forth for providing medical, dental, extended disability, life insurance, holiday, vacation, dependent day care, and other benefits to eligible employees of Eli Lilly and Company and its participating subsidiary and affiliated companies. The plan, as restated herein as of January 1, 1995, and as amended from time to time, shall be known as The Lilly Employee Welfare Plan. The Lilly Employee Welfare Plan is intended to be an "employee welfare benefit plan" as that term is defined in section 3(1) of ERISA.

1.02. Component Plans.

The Lilly Employee Welfare Plan shall be composed of the specific employee welfare benefit Component Plans designated in Schedule A, as amended from time to time.

SECTION 2. DEFINITIONS

2.01. Definitions.

(a) The following words and phrases as used in the Welfare Plan shall have the following meanings unless a different meaning is required by the context:

(1) Board of Directors. The term "Board of Directors" means the Board of Directors of the Company.

(2) Company. The term "Company" means Eli Lilly and Company.

(3) Component Plan. The term "Component Plan" means an employee welfare benefit plan that is designated on Schedule A as one of the component plans of the Welfare Plan.

(4) Employee Benefits Committee. The term "Employee Benefits Committee" means the Committee by that name appointed by the Board of Directors for the purpose of administering the Welfare Plan.

(5) Employer. The term "Employer" means the Company and any subsidiary or affiliated company specifically designated by the Board of Directors as such for the purposes of the Welfare Plan, which has heretofore adopted or which hereafter adopts the Welfare Plan by resolution of its own board of directors and which has not elected to terminate or withdraw from its participation in the Welfare Plan.

(6) ERISA. The term "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

(7) Insurance Contract. The term "Insurance Contract" means a contract or contracts between an Employer and an Insurer for the provision of benefits under a Component Plan.

(8) Insurer. The term "Insurer" means an insurance company or companies with whom an Employer has entered into an Insurance Contract for the provision of benefits under a Component Plan.

(9) Trust. The term "Trust" means the Eli Lilly and Company Master Trust for Employee Benefits, as amended from time to time. The agreement establishing the Trust is hereby incorporated by reference into, and made a part of, the Welfare Plan.

(10) Trustee. The term "Trustee" means the trustee of the Trust.

(11) Welfare Plan. The term "Welfare Plan" means The Lilly Employee Welfare Plan.

(12) Year. The term "Year" means the fiscal year of the Welfare Plan commencing January 1 and ending December 31.

(b) Gender. Masculine pronouns shall refer both to males and to females.

SECTION 3. BENEFITS

3.01. Coverage and Benefits.

The employees and other individuals covered and the benefits provided by each Component Plan shall be determined exclusively by the Component Plan instrument, and by the Insurance Contract, if any, that relates to such Component Plan.

3.02. Payment of Benefits.

Benefits provided by the Component Plans may be paid by the Trust, an Insurer, or, to the extent provided in a Component Plan, an Employer. The liability of the Trust, the Trustee, an Insurer, or an Employer to provide benefits under a Component Plan shall be limited by the terms of the Component Plan instrument, the Insurance Contract relating to such Component Plan, if any, the Trust agreement, and this Welfare Plan instrument.

3.03. Tax Withholding.

The amount of any benefit paid from the Trust to a participant or beneficiary under a Component Plan shall be reduced by the amount of any income tax or employment tax that is required to be withheld pursuant to any applicable federal, state, or local law or any applicable foreign law.

3.04. Other Adjustments.

The amount of any benefit paid from the Trust to a participant or beneficiary under a Component Plan shall be reduced by the amount of any excess benefit previously paid from the

Trust to that participant or beneficiary under that Component Plan, regardless of whether such excess payment was made by reason of an error of the Employee Benefits Committee or the Trustee or by reason of false or misleading information furnished by the participant or beneficiary or any other person. Such reduction shall continue until the entire amount of any such excess payments has been recovered.

3.05. Payment to Participant or Beneficiary.

(a) Except as otherwise provided in paragraph (b), below, benefit payments under a Component Plan shall be made to the participant in the Component Plan or his beneficiary, if any.

(b) If the Employee Benefits Committee determines that a participant or beneficiary is not competent, the Employee Benefits Committee may make benefit payments to the court-appointed legal guardian of the participant or beneficiary, to an individual who has become the legal guardian of the participant or beneficiary by operation of state law, or to another individual whom the Employee Benefits Committee determines to be entitled to receive such payments on behalf of the participant or beneficiary.

(c) If a payment of benefits is made under a Component Plan to a third party whom the Employee Benefits Committee has determined to be entitled to receive such payment on behalf of a participant or beneficiary, the Component Plan and the Employee Benefits Committee shall be relieved, to the fullest extent permitted by law, of any obligation to make a duplicative payment to or on behalf of such participant or beneficiary.

SECTION 4. ADMINISTRATION

4.01. Administrative Committee.

(a) The Welfare Plan shall be administered by the Employee Benefits Committee appointed by the Board of Directors. Except as otherwise provided in a Component Plan or in paragraph (b), below, each of the Component Plans shall also be administered by the Employee Benefits Committee. The Board of Directors may remove any member of the Employee Benefits Committee.

(b) In Component Plans in which benefits are provided by an Insurer under an Insurance Contract, the Insurer shall administer those portions of the Component Plan that are governed by the Insurance Contract.

4.02. Named Fiduciary.

(a) The Employee Benefits Committee shall be the "named fiduciary" with respect to the Welfare Plan for purposes of ERISA. Except as otherwise provided in a Component Plan or in paragraph (b), below, the Employee Benefits Committee shall be the "named fiduciary" with respect to each of the Component Plans for purposes of ERISA.

(b) In each Component Plan in which benefits are provided by an Insurer under an Insurance Contract, the Insurer shall be the "named fiduciary" for purposes of ERISA with respect to the portions of the Component Plan that are governed by the Insurance Contract.

4.03. Powers and Duties of the Employee Benefits Committee.

In addition to any implied powers and duties that may be needed to carry out the provisions of this instrument, the Employee Benefits Committee shall have the following specific powers and duties with respect to the Welfare Plan, and with respect to any Component Plan (or portion thereof) that the Employee Benefits Committee administers:

(a) To make and enforce such rules and regulations as it shall deem necessary or proper for the efficient administration of the Component Plans;

(b) To interpret this Welfare Plan instrument and any Component Plan instrument, and to decide any and all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies or omissions;

(c) To authorize disbursements from the Trust; provided that any instructions of the Employee Benefits Committee authorizing disbursements from the Trust shall be in writing and signed by a member of the Employee Benefits Committee or a delegate that has been given such authority;

(d) To employ one or more persons to render advice with respect to any of its responsibilities under the Welfare Plan or any Component Plan(s).

4.04. Delegations of Authority By the Employee Benefits Committee.

The Employee Benefits Committee may, in its discretion, delegate to any other person or persons authority to act on behalf of the Employee Benefits Committee, including but not limited to the authority to make any determination or to sign

checks, warrants, or other instruments incidental to the operation of the Welfare Plan or any Component Plan (or portion thereof) that the Employee Benefits Committee administers, or to the making of any payment specified therein.

4.05. Employment of Assistants.

SECTION 6. AMENDMENT AND TERMINATION

6.01. Amendment or Termination by the Company.

It is the intention of the Company that the Welfare Plan and its Component Plans will continue indefinitely. However, the Company reserves the right to amend, modify, suspend, revoke, or terminate the Welfare Plan or any Component Plan, in whole or in part, at any time and without notice, by resolution of the Board of Directors. The Employee Benefits Committee also shall have the right to amend or modify the Welfare Plan or any Component Plan, except that the Employee Benefits Committee may not amend or modify this Section 6 or the following Component Plans: (1) Change in Control Severance Pay Plan For Employees; (2) Change in Control Severance Pay Plan For Select Employees; and (3) The Eli Lilly and Company Holiday and Vacation Plan. The Welfare Plan and any Component Plan may be amended retroactively, in the discretion of the Board of Directors or the Employee Benefits Committee, to the extent the Employee Benefits Committee has authority to amend such plans as described herein.

6.02. Insured Component Plans --Termination of the Contract by an Employer.

In any Component Plan (or portion of such Plan) in which benefits are paid by an Insurer pursuant to an Insurance Contract, the Employer who is party to the Insurance Contract may terminate the Insurance Contract at any time by providing the Insurer with such written notice as may be required under the terms of the Insurance Contract. An Employer may enter into contracts with other insurers, or provide benefits exclusively through the Trust or through such

other funding arrangement as the Employer may establish for the purpose of providing employee welfare benefits under the Component Plan.

6.03. Amendment of Schedule A.

The Board of Directors may amend the Welfare Plan by adding a Component Plan to, or removing a Component Plan from, Schedule A.

6.04. Effect of Amendment or Termination.

(a) No amendment to or termination of the Welfare Plan or any Component Plan shall cause or permit the Trust to be used for any purpose other than the defrayal of administrative expenses and payment to participants and beneficiaries of the benefits provided under a Component Plan, except as provided in subsections 3.03 and 5.02(c).

(b) Upon termination of any Component Plan, the Trustee shall use the funds of the Welfare Plan held in the Trust to pay benefits that participants and beneficiaries have become entitled to receive under the terms of the Component Plan or, if applicable, to pay insurance premiums due an Insurer under the Component Plan, as of the date of termination, and to pay the administrative expenses incurred by the Welfare Plan and the Trust before and in connection with the termination, both in accordance with the written directions of the Employee Benefits Committee.

(c) Upon termination of the Welfare Plan, the Trustee shall use the funds of the Welfare Plan held in the Trust to pay benefits that participants and their designated beneficiaries

have become entitled to receive under the terms of the Welfare Plan, and to pay the administrative expenses incurred by the Welfare Plan and the Trust before and in connection with the termination, both in accordance with the written directions of the Employee Benefits Committee. The Trustee shall dispose of the Welfare Plan's remaining funds held in the Trust in accordance with the written directions of the Employee Benefits Committee. Such directions shall require the funds to be disposed of for the sole benefit of participants in the Welfare Plan and their beneficiaries, except as provided in subsections 3.03 and 5.02(c).

SECTION 7. MISCELLANEOUS

7.01. Governing Law.

(a) The Welfare Plan shall be governed by and administered under ERISA, and, to the extent not preempted thereby, under the laws of the State of Indiana.

(b) Except as otherwise provided in a Component Plan or in paragraph (c), below, the Component Plans shall be governed by and administered under ERISA, and, to the extent not preempted thereby, under the laws of the State of Indiana.

(c) In Component Plans in which benefits are provided by an Insurer under an Insurance Contract, the Insurance Contract shall be governed by ERISA, and, to the extent not preempted thereby, under such state law as is applicable to the Insurance Contract.

7.02. Agent for Service for Process.

The agent for service of legal process shall be the Secretary of Eli Lilly and Company, Lilly Corporate Center, Indianapolis, Indiana 46285

7.03. No Vested Rights.

To the maximum extent permitted by law, no person shall acquire any right, title, or interest in or to any portion of the Trust otherwise than by the actual payment or distribution of such portion under the provisions of the Welfare Plan or any Component Plan, or acquire any right, title, or interest in or to any benefit referred to or provided for in the Welfare Plan

or any Component Plan otherwise than by actual payment of such benefit.

7.04. Non-Alienation.

To the maximum extent permitted by law, no participant, beneficiary, or any other person shall have any right or power, by draft, assignment, or otherwise, to assign, mortgage, pledge, or otherwise encumber in advance any right, title, or interest in or to any portion of the Trust, or any benefit provided under the Welfare Plan or any Component Plan, or to give any order in advance upon the Trustee therefore; and every attempted draft, assignment, or other disposition thereof shall be void.

7.05. Spendthrift Provisions.

To the maximum extent permitted by law, the Trust shall not be liable in any way, whether by process of law or otherwise, for the debts or other obligations of any participant, beneficiary, or other person. Benefits payable under the Welfare Plan or any Component Plan shall not be subject, in any manner, to anticipation, alienation, sale, transfer, or assignment by any person, and any attempt to anticipate, alienate, sell, transfer or assign such benefits shall be void.

7.06. Non-Guarantee.

Neither an Employer nor any plan fiduciary shall be held or deemed in any manner to guarantee the Trust against loss or depreciation.

7.07. Indemnification of Certain Fiduciaries.

(a) Persons Entitled to Indemnification. Each person who is a member of the Employee Benefits Committee, the Board of Directors of the Company, or an employee of the Company or of any subsidiary or affiliated company who acts in a fiduciary capacity or any other capacity with respect to the Welfare Plan, any Component Plan, or the Trust, shall be indemnified by the Company against any and all liability and reasonable expense that may be incurred in connection with, or resulting from, any claim, action, suit, or proceeding (whether actual or threatened, and whether civil, criminal, administrative, or investigative), or in connection with any appeal relating thereto, in which he may become involved as a party or otherwise by reason of acting in any such capacity or by reason of any action taken or not taken in such capacity, whether or not such person continues to hold a position with respect to the Welfare Plan, any Component Plan, or the Trust at the time such liability or expense is incurred, provided such person acted in good faith, in what he reasonably believed to have been the best interest of the Welfare Plan, any Component Plan, the Trust, or the Company, as the case may be (and in addition, in any criminal action or proceeding, such person had no reasonable cause to believe that his conduct was unlawful).

(b) Definition. As used in this subsection 7.07 the terms "liability" and "expense" shall include, but shall not be limited to, attorneys' fees and disbursements and amounts of judgments, fines, or penalties against, and amounts paid in settlement by, such persons.

(c) Termination of Proceeding by settlement or Judgment. The termination of any claim, action, suit, or proceeding,

civil or criminal, by judgment, settlement (whether with or without court approval) or conviction or upon a plea of guilty or of nolo contenders, or its equivalent, shall not create a presumption that such person did not meet the standards of conduct set forth in paragraph (a), above.

(d) Persons Successful on the Merits. Any person described in paragraph (a), above, who has been wholly successful, on the merits or otherwise, with respect to any claim, action, suit, or proceeding of the character described in paragraph (a), above, shall be entitled to indemnification as of right.

(e) Persons not Successful on the Merits. Except as provided in paragraph (d), above, any indemnification hereunder shall be made at the discretion of the Company, but only if (i) the Board of Directors, acting by a quorum consisting of directors who are not parties to or who have been wholly successful with respect to such claim, action, suit, or proceeding, shall find that the Employee Benefits Committee member, director, or employee described in paragraph (a), above, has met the standards of conduct set forth in paragraph (a), above, or (ii) independent legal counsel (who may be regular counsel of the Company) shall deliver to the Company its written opinion that such person has met such standards.

(f) Indemnification on Less Than All Claims or Issues. If several claims, issues, or matters of action are involved, a person described in paragraph (a), above, may be entitled to indemnification as to some matters even though he is not so entitled as to others.

(g) Advance of Costs. The Company may advance expenses to, or, where appropriate, may at its expense undertake the defense of, any person described in paragraph (a), above, upon receipt of an undertaking by or on behalf of such person to repay such expenses if it should ultimately be determined that he is not entitled to indemnification under this subsection 7.07.

(h) Applicability of Indemnification Provisions. The provisions of this subsection 7.07 shall be applicable to claims, actions, suits, or proceedings made or commenced after December 31, 1985, whether arising from acts or omissions to act occurring before or after such date.

(i) Effect upon Other Rights. The rights of indemnification provided hereunder shall be in addition to any rights to which any person concerned may otherwise be entitled by contract or as a matter of law, and shall inure to the benefit of the heirs, executors, and administrators of any such person.

7.08. Employment Rights.

Neither the establishment nor the continuance of the Welfare Plan or of any Component Plan shall be construed as conferring any legal rights upon any employee of an Employer or any other person for a continuation of employment, nor shall such establishment or continuance interfere with the right of an Employer to discharge any employee or any other person or to deal with him without regard to the existence of the Welfare Plan or any Component Plan.

20a

ELI LILLY AND COMPANY

EXTENDED DISABILITY PLAN

Effective August 1, 1972
As Amended Effective January 1, 2002

TABLE OF CONTENTS

Page

Section 1. Establishment and Restatement 23a

1.01. The Establishment of the Plan. 23a
1.02. The Lilly Employee Welfare Plan 23a
1.03. Effective Date 23a

Section 2. Definitions 24a
2.01. Definitions 24a

Section 3. Eligibility 38a

3.01. Eligibility for Company-Provided Disability Benefit 38a
3.02. Eligibility for EDL PLUS Disability Benefit 38a
3.03. Termination and Reinstatement of Eligibility 39a
3.04. Recurrent Disability 40a
3.05. Rehabilitative Employment 42a

Section 4. Duration and Amount of Company-provided Disability Benefit AND EDL PLUS Disability Benefit 43a

4.01. Commencement of Company-Provided Disability Benefit or EDL PLUS Disability Benefit 43a
4.02. Duration of Company-Provided Disability Benefit or EDL PLUS Disability Benefit: Generally 43a

4.03. Duration of Company-Provided Disability Benefit and EDL PLUS Disability Benefit: Rehabilitative Employment 44a
4.04. Duration of Company-Provided Disability Benefit and EDL PLUS Disability Benefit: No Objective Medical Evidence 45a
4.05. Amount of Company-Provided Disability Benefit and EDL PLUS Disability Benefit . 45a
4.06. Adjustment for Rehabilitative Employment . 48a
4.07. Limitation on Amount of Benefit 48a

Section 5. Death Benefit 46a

5.01. Eligibility For Death Benefit 49a
5.02. Designation of Beneficiary 49a
5.03. Amount of Death Benefit 50a

Section 6. Claims 50a

6.01. Time Requirements for Claims 50a
6.02. Proof of Claims 51a
6.03. Approval of Claims 52a
6.04. Inability To Locate Employee 53a
6.05. Claims Procedure 54a

SECTION 1. ESTABLISHMENT AND RESTATEMENT

1.01. The Establishment of the Plan.

Eli Lilly and Company has established, effective August 1, 1972, a plan as hereinafter set forth for providing certain extended disability benefits to its eligible employees. The plan, as stated herein and as amended from time to time, shall be known as The Lilly Extended Disability Plan.

1.02. The Lilly Employee Welfare Plan.

Effective January 1, 1986, the Plan shall be part of The Lilly Employee Welfare Plan, a program established to provide medical, dental, extended disability, life insurance, holiday, vacation, and other benefits to eligible employees of Eli Lilly and Company and their beneficiaries. The provisions of The Lilly Employee Welfare Plan are, to the extent applicable, incorporated herein by reference.

1.03. Effective Date.

The Lilly Extended Disability Plan, as herein amended and restated, shall be effective as of January 1, 1999, with respect to Employees who were eligible for Company-Provided Disability Benefit or EDL PLUS Disability Benefit payments under the Plan as of that date and with respect to those Employees who become eligible for Company-Provided Disability Benefit or EDL PLUS Disability Benefit payments under the Plan on or after that date.

SECTION 2. DEFINITIONS

2.01. Definitions.

(a) The following words and phrases as used in the Plan shall have the following meanings unless a different meaning is required by the context:

(1) Average Final Earnings. The term "Average Final Earnings" means one-twelfth (1/12) of the Employee's average annual Earnings for the five (5) calendar years in which the Employee had the greatest amount of Earnings during the last ten (10) calendar years of employment for the Company or a Qualified Subsidiary immediately preceding the date on which the Employee incurred a Disability, or one-twelfth (1/12) of the Employee's average annual Earnings for all such calendar years, if less than five (5).

(2) Company. The term "Company" means Eli Lilly and Company.

(3) Company-Provided Disability Benefit. The term "Company-Provided Disability Benefit" means one or more monthly payments made under the Plan to an Employee because of the Employee's Disability.

(4) Controlled Group. The term "Controlled Group" means a controlled group of corporations (within the meaning of Section 1563(a) of the Internal Revenue Code of 1986, as amended, determined without regard to Sections 1563(a)(4) and (e)(3)(C) of the Internal Revenue Code) of which the Company is a member.

(5) Disability. The term "Disability" means the inability of an Employee to engage, for remuneration or profit, in any occupation commensurate with the Employee's education, training, and experience, provided that the inability results from an illness or accidental bodily injury that requires the Employee to be under the regular care of a Licensed Physician. The term "Disability" shall not include an inability that is attributable to war, declared or undeclared, or any act of war; to intentionally self-inflicted injuries; or to active participation in a riot. An Employee who has been determined by the Employee Benefits Committee to have a Disability shall sometimes be described herein as being "Disabled."

(6) Disability Date. The term "Disability Date" means the later to occur of the following:

(A) the last day for which an Employee who is Disabled receives pay under any temporary illness pay or short-term disability program (other than a worker's compensation program) maintained by the Company or a Qualified Subsidiary; or

(B) the date as of which the Employee Benefits Committee makes a final determination that the Employee is Disabled.

(7) Early Retirement Benefit Equivalent. The term "Early Retirement Benefit Equivalent" means the monthly "early retirement benefit" (as defined in section 4.02 of the Retirement Plan) that a Disabled Employee is eligible to receive under the Retirement Plan,

assuming, for purposes of this paragraph (7) only, that:

(A) the Disabled Employee has retired;

(B) with respect to a Disabled Employee who does not otherwise qualify for an "early retirement benefit" under section 3.02(b) of the Retirement Plan, the sum of the age and Years of Service of the Employee equals eighty (80), and the Employee has reached the fifth (5th) anniversary of his commencement of participation in the Retirement Plan;

(C) for purposes of calculating such benefit, the assumed age and "Benefit Years of Service" (as defined in the Retirement Plan) of a Disabled Employee, as described in (B) above, will be taken into account;

(D) the retirement benefit will be received in the form of a single life annuity; and

(E) any offset for any benefits payable to the Employee under any other qualified defined benefit plan maintained by the Company or any member of the Controlled Group will be disregarded.

(8) Earnings.

(A) The term "Earnings" means:

(i) regular compensation, overtime, and other forms of additional compensation determined by and paid currently pursuant to an established formula or procedure, and

(ii) salary reduction contributions to The Lilly Employee Savings Plan or elective contributions under any similar tax-qualified plan that is intended to meet the requirements of Section 401(k) of the Internal Revenue Code, and

(iii) elective contributions to any cafeteria plan that is intended to meet the requirements of Section 125 of the Internal Revenue Code.

(B) The term "Earnings" shall not include:

(i) compensation paid in lieu of earned vacation; or

(ii) amounts contributed to the Retirement Plan or any other qualified plan, except as provided in clause (A)(ii), above; or

(iii) payments based upon the discretion of the Company, Qualified Subsidiary, or member of the Controlled Group; or

(iv) in the case of a person employed by a Qualified Subsidiary, foreign service, cost of living, or other allowances that would not be paid were the person employed by the Company; or

(v) amounts paid as commissions, sales bonuses, or Market Premiums (as defined under the Retirement Plan).

(C) Earnings during any period of leave of absence for military service shall be assumed to be at the same basic rate as earnings immediately preceding the period of leave.

(9) EDL PLUS Disability Benefit. The term "EDL PLUS Disability Benefit" means one or more monthly payments made under the Plan, because of an Employee's Disability, to an Employee who is receiving the Company-Provided Disability Benefit on account of such Disability and who has EDL PLUS coverage in effect under the terms of the Flexible Benefits Plan. An Employee under age 65 may elect EDL PLUS coverage in accordance with the Flexible Benefits Plan by electing to forego Earnings in the amount required for such coverage.

(10) Employee. The term "Employee" means a person

(A) who is employed as a common law employee by, and receives regular compensation, including temporary illness pay, from the Company or a Qualified Subsidiary, and

(B) who is ordinarily employed by the Company or a Qualified Subsidiary for 20 or more hours per week and 5 months per year, and

(C) who is not a "leased employee" within the meaning of Section 414(n) of the Internal Revenue Code, and

(D) who is not classified as a special status employee because his employment status is temporary, seasonal, or otherwise inconsistent with regular employment status, and

(E) who is accruing benefits under the Retirement Plan at the time Disability occurs, or who would be accruing benefits under the Retirement Plan if Section 415 of the Internal Revenue Code were disregarded.

Solely for purposes of the Plan, an individual who satisfied the requirements of clauses (A) through (E), above, immediately before he incurred a Disability shall be deemed to be an Employee while he is eligible to receive a Company-Provided Disability Benefit or EDL PLUS Disability Benefit under the Plan.

Notwithstanding anything herein to the contrary, the term Employee shall not include any person who is not so recorded on the payroll records of the Company or Qualified Subsidiary, as applicable, including any such person who is subsequently reclassified by a

court of law or regulatory body as a common law employee of such Company or Qualified Subsidiary. Consistent with the foregoing, and for purposes of clarification only, the term Employee does not include any individual who performs services for the Company or Qualified Subsidiary, as applicable, as an independent contractor or under any other non-employee classification. (Subsection 2.01(a)(10) is effective April 1, 2001.)

(11) Employee Benefits Committee. The term "Employee Benefits Committee" means the Committee by that name appointed by the Board of Directors of the Company for the purpose of administering the Plan or its designee.

(12) Final Pay. The term "Final Pay" means an Employee's regular monthly compensation, overtime and other forms of additional compensation determined by and paid pursuant to an established formula or procedure, determined as of the date on which the Employee incurs a Disability, including salary reduction contributions to a cafeteria plan that is intended to meet the requirements of Section 125 of the Internal Revenue Code or salary reduction contributions to a cash or deferred arrangement that is intended to meet the requirements of Section 401(k) of the Internal Revenue Code, but excluding all other amounts contributed to any tax-qualified plan by or on behalf of the Employee.

(13) Flexible Benefits Plan. The term "Flexible Benefits Plan" means The Eli Lilly and Company

Flexible Benefits Plan, as amended from time to time.

(14) Legislative Benefit. The term "Legislative Benefit" means the aggregate amount of the monthly disability income benefits available pursuant to federal, state, or municipal legislation, or pursuant to foreign legislation, as a result of an Employee's employment, regardless of whether the Employee actually receives such benefits, provided that the Employee Benefits Committee determines that the nature and severity of the Employee's Disability makes him eligible to apply for benefits pursuant to such legislation. The term "Legislative Benefit" shall include, but shall not be limited to, the following:

(A) any Social Security disability benefit, Railroad Retirement disability benefit, occupational disease benefit (other than a worker's compensation benefit), or other periodic cash disability income benefit that the Employee Benefits Committee determines is payable with respect to an Employee, or any such benefit that the Employee Benefits Committee determines would be payable with respect to an Employee if the Employee had applied for such benefit and had completed any waiting period applicable to such benefit; and

The term "Legislative Benefit" shall not include any worker's compensation benefit.

(15) Licensed Physician. The term "Licensed Physician" means a physician, other than the Employee, who is acting within the scope of his or her license. If Disability is due to a Mental Illness, Licensed Physician means a psychiatrist or licensed doctoral level psychologist other than the Employee.

(16) Life Insurance Plan. The term "Life Insurance Plan" means The Eli Lilly and Company Life Insurance and Death Benefit Plan, as adopted by the Board of Directors of the Company effective January 1, 1992, as amended from time to time.

(17) Mental Illness. The term "Mental Illness" means any disease, condition or disorder, whether organic or inorganic, customarily within the scope of treatment of psychiatrists, psychologists, psychotherapists, or counselors. This includes, but is not limited to:

(A) psychosis, psychoneurosis, anxiety, and depression; and

(B) behavioral, adjustment, emotional, personality, and stress-related disorders.

(18) Normal Retirement Age. The term "Normal Retirement Age" means Normal Retirement Age under the Retirement Plan, as defined in Section 3.02(a) of the Retirement Plan.

(19) Objective Medical Evidence. The term "Objective Medical Evidence" means "medical signs"

(including psychiatric signs) and "laboratory findings," as documented by a Licensed Physician regarding disability status.

(A) Medical signs are anatomical, physiological, or psychological abnormalities that can be observed, apart from subjective statements of symptoms. Medical signs must be shown by medically acceptable clinical diagnostic techniques. Psychiatric signs are medically demonstrable phenomena that indicate specific abnormalities of behavior, affect, thought, memory, orientation, and contact with reality. They must also be shown by observable facts that can be medically described and evaluated.

(B) Laboratory findings are anatomical, physiological, or psychological phenomena that can be shown by the use of medically acceptable laboratory diagnostic techniques. Some of these diagnostic techniques include chemical tests, electrophysiological studies (electrocardiogram, electroencephalogram, etc.), roentgenological studies (x-rays), and psychological tests.

(20) Plan. The term "Plan" means The Lilly Extended Disability Plan, as herein set forth and as amended from time to time.

(21) Prior Condition. The term "Prior Condition" means a sickness, injury or infirmity suffered by an Employee, on or prior to the Employee's date of employment (i) by the Company, (ii) by a

Qualified Subsidiary, or (iii) by any member of the Controlled Group. In the case of an Employee who terminates employment with the Company, a Qualified Subsidiary, or a member of the Controlled Group and is later rehired, the Employee's most recent date of employment by the Company, a Qualified Subsidiary, or a member of the Controlled Group shall be used to determine whether the Employee has a Prior Condition.

(22) Qualified Subsidiary. The term "Qualified Subsidiary" means a corporation that is either:

(A) a foreign corporation not less than 10 percent of the voting stock of which is owned directly or through one or more entities by the Company, but only if the Company has entered into an agreement under Section 3121(1) of the Internal Revenue Code or the corresponding provision of any subsequent revenue law that applies to such foreign corporation, and such agreement remains in effect; or

(B) a domestic corporation not less than 80 percent of the voting stock of which is owned by the Company, 95 percent or more of the gross income of which, for the three-year period immediately preceding the close of the taxable year (or for such part of such period during which the corporation was in existence), was derived from sources without the United States, and 90 percent or more of the gross

income of which for such period (or such part) was derived from the active conduct of a trade or business.

(23) Recurrent Disability. The term "Recurrent Disability" means a Disability that is related to a prior Disability for which an Employee received a Company-Provided Disability Benefit or an EDL PLUS Disability Benefit.

(24) Rehabilitative Employment. The term "Rehabilitative Employment" means work in any gainful occupation, other than an Employee's regular occupation, for which the Employee is reasonably fitted by training, education, or experience, provided that such Rehabilitative Employment is performed during a period in which the Employee is unable fully to perform his regular occupation. The term "Rehabilitative Employment" also includes work in an Employee's regular occupation on a work schedule that is substantially reduced from the schedule that the Employee followed immediately before he incurred a Disability.

(25) Rehabilitative Employment Period. The term "Rehabilitative Employment Period" means the period that begins on the date on which the Employee accepts Rehabilitative Employment, and that ends on the earliest of the following dates:

(A) the date specified in paragraph (b), (c), or (d) of subsection 4.02, below; or

(B) the date on which the Employee ceases to engage in Rehabilitative Employment, provided that the Employee is not Disabled on the date on which he ceases to engage in Rehabilitative Employment.

(26) Retirement Plan. The term "Retirement Plan" means The Lilly Retirement Plan, as adopted by the Board of Directors of the Company effective January 1, 1944, as amended from time to time.

(27) Trust. The term "Trust" means the Eli Lilly and Company Master Trust for Employee Benefits, as amended from time to time. The agreement establishing the Trust is hereby incorporated by reference into, and made a part of, the Plan, except to the extent that it expressly conflicts with the terms of this Plan.

(28) Trustee. The term "Trustee" means the trustee of the Eli Lilly and Company Master Trust for Employee Benefits.

(29) Welfare Plan. The term "Welfare Plan" means The Lilly Employee Welfare Plan, as amended from time to time. The provisions of the Welfare Plan, including those governing administration, review of claims, amendment and miscellaneous matters, are hereby incorporated by reference into, and made a part of, this Plan, except to the extent that they expressly conflict with the terms of this Plan.

(30) Year of Service. The term "Year of Service" means a year of service as defined in The Retirement Plan.

(b) Gender. Masculine pronouns shall refer both to males and to females.

SECTION 3. ELIGIBILITY

3.01. Eligibility for Company-Provided Disability Benefit.

(a) An eligible Employee whose active employment terminates because of Disability shall be entitled to receive a Company-Provided Disability Benefit under the terms of the Plan as in effect on his Disability Date.

(b) An Employee shall not be entitled to receive a Company-Provided Disability Benefit if his employment terminates because of Disability while he is on a paid or unpaid leave of absence, unless such Disability occurs on or before the end of the month immediately following the month in which the leave of absence begins.

(c) An Employee shall not be entitled to receive a Company-Provided Disability Benefit if the Disability is attributable to a Prior Condition, unless such Disability occurs after such Employee has completed at least five (5) Years of Service following his most recent date of employment by the Company, a Qualified Subsidiary, or any member of the Controlled Group.

3.02. Eligibility for EDL PLUS Disability Benefit.

(a) An eligible Employee whose active employment terminates because of Disability shall be entitled to receive an EDL PLUS Disability Benefit under the terms of the Plan as in effect on his Disability Date, provided that the Employee is entitled to the Company-Provided Disability Benefit on account of such Disability, and the Disability Date occurs on a date when the Employee has EDL PLUS

coverage in effect under the terms of the Flexible Benefits Plan.

(b) An Employee shall not be entitled to receive an EDL PLUS Disability Benefit if his employment terminates because of Disability while he is on a paid or unpaid leave of absence, unless such Disability occurs on or before the end of the month immediately following the month in which the leave of absence begins.

(c) If an Employee:

(1) did not elect EDL PLUS coverage within the period the Employee was first eligible to do so under the terms of the Flexible Benefits Plan, or

(2) elected under the terms of the Flexible Benefits Plan to end a prior period of EDL PLUS coverage, and

the Employee subsequently elects or re-elects, as applicable, EDL PLUS coverage, then such Employee shall not be entitled to receive an EDL PLUS Disability Benefit for a Disability that is attributable to an illness or injury that was diagnosed or treated during the twelve (12) month period immediately prior to the date of the Employee's subsequent election of EDL Coverage, unless such Disability occurs at least twenty-four (24) months after the date of such subsequent election.

3.03. Termination and Reinstatement of Eligibility.

(a) An Employee's eligibility to participate in the Plan shall terminate on the earlier of (i) the date on which he ceases

to be an Employee, or (ii) the date on which the Plan terminates.

(b) If an individual's eligibility to participate in the Plan terminates because he has ceased to be an Employee, he shall be eligible to resume his participation in the Plan as of the date on which he again meets the definition of an Employee in clauses (B) through (F) of subsection 2.01(a)(11) of the Plan.

3.04. Recurrent Disability.

(a) This subsection 3.04 shall apply only to an individual who is employed by the Company and who qualifies as an Employee following a period of Disability; it shall not be deemed to create any rights in any individual who suffers a Recurrent Disability while such individual is not employed by the Company or a Qualified Subsidiary as an Employee. This subsection 3.04 shall not apply to an individual who is unable to return to his regular occupation at the Company and to follow his regular work schedule as described in paragraph (b)(1), below, but who is employed by the Company in Rehabilitative Employment.

(b) An Employee's Recurrent Disability shall be treated as a new period of Disability for all purposes under the Plan if, immediately following the termination of his period of Disability, the Employee

(1) returned to his regular occupation at the Company or a Qualified Subsidiary (or to an occupation at the Company or a Qualified Subsidiary that requires similar skills, training, and experience) on the work schedule that he followed immediately before he incurred a Disability, and

(2) performed all of the material duties of his occupation, and

(3) worked continuously in his occupation for at least three months before he incurred a Recurrent Disability.

(c) If an Employee returns to employment with the Company or a Qualified Subsidiary but fails to meet one or more of the requirements of paragraph (b), above, the Employee's Recurrent Disability shall be treated as part of the Employee's prior Disability. A Recurrent Disability that is treated as part of an Employee's prior Disability pursuant to this paragraph (c) shall be subject to the following rules:

(1) The Employee's Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit, as applicable, shall recommence as of the first day of the month following the month in which his active employment terminates because of the Recurrent Disability, and

(2) The amount of the Employee's Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit shall be the same as the amount of the Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit, as applicable, that he

received during his prior Disability (subject, however, to adjustment to reflect any differences in the compensation that the Employee receives or formerly received for Rehabilitative Employment).

3.05. Rehabilitative Employment.

If an Employee accepts Rehabilitative Employment while he is receiving a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit under the Plan, the Employee shall remain eligible to receive a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit, as applicable, under the Plan to the extent provided in Section 4, below, and the amount and duration of the Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit payable with respect to such Employee shall be adjusted as provided in Section 4, below.

SECTION 4. DURATION AND AMOUNT OF COMPANY-PROVIDED DISABILITY BENEFIT AND EDL PLUS DISABILITY BENEFIT

4.01. Commencement of Company-Provided Disability Benefit or EDL PLUS Disability Benefit.

Payment of an Employee's Company-Provided Disability Benefit or EDL PLUS Disability Benefit, as applicable, shall commence as of the first day of the month immediately following the month in which such Employee's Disability Date occurs.

4.02. Duration of Company-Provided Disability Benefit or EDL PLUS Disability Benefit: Generally.

Except as otherwise provided in subsection 4.03(b) or subsection 4.04, below, Company-Provided Disability Benefit payments or EDL PLUS Disability Benefit payments, as applicable, shall cease as of the last day of the month during which the earliest of the following events occurs:

(a) the Employee is no longer Disabled;

(b) the Employee dies;

(c) if the Employee was age 60 or less on the Disability Date, the Employee reaches age 65; or

(d) if the Employee was over age 60 on the Disability Date, 5 years have elapsed since the Disability Date.

4.03. Duration of Company-Provided Disability Benefit and EDL PLUS Disability Benefit: Rehabilitative Employment.

(a) Except to the extent provided in subsection 4.03(b), below, an Employee who becomes able to engage, for remuneration or profit, in any occupation commensurate with such Employee's education, training, and experience shall cease to be Disabled for purposes of the Plan, regardless of whether the Employee actually engages in such an occupation.

(b) If an Employee accepts Rehabilitative Employment after he qualifies for a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit, as applicable, and before such Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit terminates, he shall continue to be treated as a Disabled Employee for all purposes of the Plan during the Rehabilitative Employment Period. The Employee's Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit during the Rehabilitative Employment Period shall be reduced as described in subsection 4.06, below.

(c) If an Employee accepts Rehabilitative Employment and then terminates such Rehabilitative Employment because the Employee has become Disabled again, and if the termination of such Rehabilitative Employment occurs before the expiration of the Rehabilitative Employment Period, the Rehabilitative Employment Period shall be treated as a continuation of such Employee's prior Disability for purposes of computing the amount and duration of the Employee's Company-Provided Disability

Benefit and/or EDL PLUS Disability Benefit, as applicable.

4.04. Duration of Company-Provided Disability Benefit and EDL PLUS Disability Benefit: No Objective Medical Evidence.

Notwithstanding any other provisions of this Plan, Company-Provided Disability Benefit and EDL PLUS Disability Benefit payments will be provided for a maximum period of 24 months for any illness or bodily injury that is not susceptible to proof by Objective Medical Evidence documented by a Licensed Physician.

4.05. Amount of Company-Provided Disability Benefit and EDL PLUS Disability Benefit.

(a) If the Disability Date occurs prior to the Employee's attainment of Normal Retirement Age under the Retirement Plan and prior to the Employee's voluntary election to receive a retirement benefit under the Retirement Plan, the Company-Provided Disability Benefit shall be equal to the greater of:

(1) the Early Retirement Benefit Equivalent, or

(2) 50 percent of the Employee's Average Final Earnings, less the Legislative Benefit; provided that, if the amount of the Company-Provided Disability Benefit is determined pursuant to this paragraph (a), the amount of the Company-Provided Disability Benefit shall be

redetermined pursuant to paragraph (b), below, of this subsection 4.05 upon the Employee's attainment of Normal Retirement Age under the Retirement Plan, or pursuant to paragraph (c), below, of this subsection 4.05 upon the Employee's voluntary election to receive a retirement benefit under the Retirement Plan.

(b) If the Disability Date occurs after the Employee's attainment of Normal Retirement Age under the Retirement Plan, the amount of the Company-Provided Disability Benefit shall be equal to the greater of:

(1) the Early Retirement Benefit Equivalent, or

(2) 50 percent of the Employee's Average Final Earnings, less the Legislative Benefit;

less any monthly "normal retirement benefit" (as defined in section 4.01 of the Retirement Plan) such Employee is eligible to receive under the Retirement Plan, assuming, for purposes of this paragraph 4.05(b) only, that the "normal retirement benefit" will be received in the form of a "joint and survivor annuity" (as described in section 5.01(b) of the Retirement Plan).

(c) If the Disability Date occurs after the Employee's voluntary election to receive a retirement benefit under the Retirement Plan, the amount of the Company-Provided Disability Benefit shall be equal to the greater of:

(1) the Early Retirement Benefit Equivalent, or

(2) 50 percent of the Employee's Average Final Earnings, less the Legislative Benefit; less any monthly retirement

benefit such Employee is receiving under the Retirement Plan.

(d) If the Disability Date occurs on a date when an Employee has EDL PLUS coverage in effect under the terms of the Flexible Benefits Plan and the Employee is entitled to Company-Provided Disability Benefit for the Disability, he shall be entitled to an EDL PLUS Disability Benefit of 15 percent of his Average Final Earnings.

(e) Notwithstanding any provision in paragraph (a), (b), (c), or (d) above,

(1) the Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit, as applicable, of any Employee receiving a worker's compensation benefit, shall be reduced by the amount of such worker's compensation benefit; and

(2) the Company-Provided Disability Benefit calculated under subparagraphs 4.05(a)(2), 4.05(b)(2), or 4.05(c)(2) shall be redetermined pursuant to subparagraph 4.05(a)(1), 4.05(b)(1), or 4.05(c)(1), above, on the tenth anniversary of the Disability Date, provided that

(A) if the Disability Date is on or before December 31, 1998, the Company-Provided Disability Benefit shall not be so redetermined until the Employee's attainment of age 55 and thereafter; and

(B) if the Disability Date occurs between January 1, 1999, and December 31, 2000, the amount

of the Company-Provided Disability Benefit shall not be so redetermined until the later of (i) the tenth anniversary of the Disability Date, or (ii) the Employee's attainment of age 55, and thereafter.

4.06. Adjustment for Rehabilitative Employment.

If an Employee receives compensation for Rehabilitative Employment while he is receiving a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit, as applicable, the amount of the Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit shall be reduced so that the sum of the Employee's Company-Provided Disability Benefit, the EDL PLUS Disability Benefit, the Legislative Benefit, and compensation for Rehabilitative Employment does not exceed 100 percent of the Employee's Final Pay.

4.07. Limitation on Amount of Benefit.

At such times as the sum of the Company-Provided Disability Benefit, the EDL PLUS Disability Benefit, the Legislative Benefit, and post-disability earnings of the Employee exceeds 100 percent of such Employee's Final Pay, the amount of the Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit determined under subsection 4.05 shall be reduced by the amount by which the sum of the Company-Provided Disability Benefit, the EDL PLUS Disability Benefit, the Legislative Benefit, and any post-disability earnings of the Employee exceeds 100 percent of such Employee's Final Pay.

SECTION 5. DEATH BENEFIT

5.01. Eligibility For Death Benefit.

A Disabled Employee's "uninsured coverage" under the Life Insurance Plan shall be discontinued upon the earliest of the following to occur:

(a) the fifth anniversary of the Disabled Employee's Disability Date;
(b) effective on and after January 1, 2000, the date upon which the sum of the Disabled Employee's age and Years of Service equals 80, as determined pursuant to the provisions of the Retirement Plan then in effect (but such date shall be deemed to be January 1, 2000 if the Disabled Employee's age and Years of Service equal or exceed 80 as of December 31, 1999); or
(c) when the Disabled Employee ceases to be an Employee. A Disabled Employee shall become eligible for the death benefit described in subsections 5.02 and 5.03, below, effective as of the date on which his coverage under the Life Insurance Plan is discontinued.

5.02. Designation of Beneficiary.

The death benefit shall be payable in a lump sum to the beneficiary of any deceased Employee whose coverage under the Life Insurance Plan had been discontinued pursuant to subsection 5.01, above, and who was receiving a Company-Provided Disability Benefit at the time of death. The death benefit shall be paid to the beneficiary or beneficiaries named by the Employee under the Life Insurance Plan at the time coverage under the Life Insurance Plan was discontinued, unless the Employee filed written notice with

the Employee Benefits Committee designating a different beneficiary.

5.03. Amount of Death Benefit.

The amount of the death benefit shall be $5,000.

SECTION 6. CLAIMS

6.01. Time Requirements for Claims.

(a) Notice of Claim. An Employee who intends to file a claim for a Company-Provided Disability Benefit or EDL PLUS Disability Benefit must notify the Employee Benefits Committee in writing within 30 days from the date on which the Disability commences.

(b) Proof of Claim. An Employee must provide the Employee Benefits Committee with proof of the Employee's entitlement to a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit (including any available Objective Medical Evidence) within 90 days after the expiration of the 30-day period described in paragraph (a), above.

(c) Extension of Time. The Employee Benefits Committee may accept a notice of the Employee's claim, or proof of the Employee's claim (including Objective Medical Evidence), after the expiration of the applicable period described in paragraph (a) or (b), above, provided that the Employee

(1) shows good cause for his delay in submitting the required notice or proof, and

(2) submits the required notice or proof as soon as he is reasonably able to do so.

In no event, however, may the Employee Benefits Committee accept a notice of the Employee's claim or proof of the Employee's claim (including Objective Medical Evidence) more than one year after the expiration of the applicable period described in paragraph (a) or (b), above.

6.02. Proof of Claims.

(a) An Employee who claims to be entitled to a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit shall submit to the Employee Benefits Committee, at the Employee's own expense, the following information:

(1) the date on which the Employee's Disability commenced;

(2) the cause of the Disability;

(3) any available Objective Medical Evidence of the Disability;

(4) the nature and extent of the Disability;

(5) the name and address of the Licensed Physician who is providing the Employee with regular care; and

(6) such other information as the Employee Benefits Committee shall reasonably require in order to determine whether the Employee is eligible for a

Company-Provided Disability Benefit or EDL PLUS Disability Benefit.

Failure to provide the information specified in this paragraph (a) shall result in the denial of an Employee's claim for Company-Provided Disability Benefit or EDL PLUS Disability Benefit payments, as applicable.

(b) The Employee Benefits Committee may require an Employee to undergo examination by a Licensed Physician or vocational expert chosen by the Employee Benefits Committee to determine the extent of any illness or injury for which the Employee makes a claim under the Plan. The Employee Benefits Committee may require an Employee to undergo such examinations as often as is reasonably necessary to determine whether the Employee remains Disabled. The Trustee shall pay out of the Trust the expense of any examination required by the Employee Benefits Committee pursuant to this paragraph (b); provided that if the Company or a Qualified Subsidiary notifies the Trustee that the Company or such Qualified Subsidiary has paid or will pay any expense described in this sentence, the Trustee shall not pay such expense out of the Trust.

6.03. Approval of Claims.

(a) The Employee Benefits Committee shall have the discretion to construe the terms of the Plan and to determine whether an Employee has incurred a Disability, whether the Employee has submitted Objective Medical Evidence, the amount of the Employee's Average Final Earnings, the amount of the Employee's Final Pay, whether the Employee is eligible to receive any

Legislative Benefit, the amount of any Legislative Benefit that the Employee is eligible to receive, and any other matter concerning an Employee's eligibility for benefits under the Plan.

(b) The Employee Benefits Committee shall have the discretion to make any finding of fact necessary for the determination of any benefit payable under the Plan. The Employee Benefits Committee may review its prior determination from time to time to ascertain whether there has been any change in the facts or conditions on which the determination was based.

6.04. Inability To Locate Employee.

The Employee Benefits Committee will make reasonable efforts to locate any Employee who has established an entitlement to receive a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit, as applicable. If, despite these efforts, the Employee Benefits Committee fails to locate an Employee, the following rules shall apply:

(a) If the Employee is located by the Employee Benefits Committee within six months after the date on which he last received a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit, as applicable, and if he can demonstrate that he continues to have a Disability, the Company shall restore the Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit that the Employee would have received during the period from the date on which he last received a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit until the time he was located by the Employee Benefits Committee;

(b) If the Employee is located by the Employee Benefits Committee more than six months after the date on which he last received a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit, as applicable, and if he can demonstrate that he continues to have a Disability, the Company shall restore the Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit that the Employee would have received during the period from the date on which he last received a Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit until six months after such date.

In either of the cases described in paragraphs (a) and (b), above, the Employee's Company-Provided Disability Benefit and/or EDL PLUS Disability Benefit, as applicable, shall recommence as of the first day of the month following the date on which he was located by the Employee Benefits Committee.

6.05. Claims Procedure.

(a) Initial Claims. If a claim for disability benefits is wholly or partially denied, the Employee Benefits Committee (or its delegate) shall give the claimant notice of its adverse benefit determination within a reasonable time, but not later than 45 days after receipt of the claim. This determination period may be extended twice by 30 days if, prior to the expiration of the initial 45-day period, the Employee Benefits Committee (or its delegate) determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary, the notice of extension shall

specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The claimant will be afforded at least 45 days within which to provide the specified information.

The notice of an adverse benefit determination shall be written in a manner calculated to be understood by the claimant and shall set forth the following:

(1) the specific reason(s) for the adverse benefit determination;
(2) reference to the specific plan provisions on which the determination is based;
(3) a description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary;
(4) a description of the Plan's claims review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
(5) any internal rule, guideline, or protocol relied on in making the adverse determination (or state that such information is available free of charge upon request); and
(6) when the claim is denied based on a medical necessity or an experimental treatment exclusion, an explanation of the scientific or clinical basis of the determination (or state that such information is available free of charge upon request).

(b) Appeal of Adverse Benefit Determinations. The claimant shall have 180 days from the receipt of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the adverse benefit determination. A final decision on review will be made within a reasonable period of time, but not later than 45 days following the Plan's receipt of the written request for review. If the Employee Benefits Committee (or its delegate) determines that special circumstances require an extension of time for a final decision on review, the review period may be extended by an additional 45 days (90 days in total). The Employee Benefits Committee (or its delegate) will notify the claimant of the extension prior to the expiration of the first 45-day period and shall identify the special circumstances requiring the extension and the date by which the Plan expects to render the determination on review.

The Employee Benefits Committee (or its delegate) shall issue a decision, which shall be written in a manner calculated to be understood by the claimant and shall set forth the following:

(1) the specific reason(s) for the adverse determination;

(2) reference to the specific provisions of the Plan on which the benefit determination is based;

(3) a statement that the claimant is entitled to receive, free of charge, reasonable access to and copies of all documents relevant to the claim (within the meaning of Lab. Reg. § 2560.503-1(m)(8));

(4) a statement describing any voluntary appeal procedures offered by the Plan;

(5) a statement of the claimant's right to bring an action under section 502(a) of ERISA;

(6) any internal rule, guideline, or protocol relied on in making the adverse determination (or state that such information is available free of charge upon request);

(7) when claim is denied based on medical necessity or an experimental treatment exclusion, an explanation of the scientific or clinical basis of the determination (or state that such information is available free of charge upon request); and

(8) the statement specified in Lab. Reg. § 2560.503-1(j)(5)(iii)).

Claimants will have the opportunity to submit written comments, documents, or other information in support of their appeals. Claimants will have access to all relevant documents (within the meaning of Lab. Reg. § 2560.503-1(m)(8)) and may request the identification of any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by the Employee Benefits Committee (or its delegate) and will be made by a person different from the person who made the initial determination and such person will not be the original decisionmaker's subordinate. In the case of a claim denied on the grounds of medical necessity or experimental treatment, the Employee Benefits Committee (or its delegate) will consult with a health professional with appropriate training. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or his subordinate, if applicable.

(c) Effective Date. This subsection 6.05 shall be effective for all claims filed under the Plan on or after January 1, 2002.